



At-Risk Child Care Application and Authorization

Authorization INITIAL AUTHORIZATION REDETERMINATION UPDATE
 If update, change in: Hours Children Address Custody
 Eligibility Extension Termination of Care Worker/Unit

TO:	FROM: (Print Worker Name)	EMAIL ADDRESS:
	Unit, Number & Address	
	City, Zip Code	

SECTION A: CLIENT/FAMILY INFORMATION If address for parent/guardian is a P.O. Box, enter street address in "Comments" below.

Social Security No.	Last Name First Name MI (Print)	Date of Birth	Gender	Race
Social Security No.	Spouse or Other Parent (if applicable) (Print): Last Name First Name MI	Date of Birth	Gender	Race
Address		City	State	Zip
			Day Time Phone No.	Evening Phone No.

If there is NO spouse: enter the Marital Status: Single Divorced Widowed Separated

Parent/ (if different from above):	Last Name First Name MI (Print)	Social Security No.	Date of Birth	Gender	Race
Address		City	State	Zip	
			Day Time Phone No.	Evening Phone No.	

SECTION B: ELIGIBILITY

I. Status:	<input type="checkbox"/> Assistance <input type="checkbox"/> Non-Assistance	Rilya Wilson Act: <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> At Risk: <input type="radio"/> PI <input type="radio"/> PS <input type="radio"/> FC <input type="radio"/> Diversion	
	<input type="checkbox"/> Placement Location: <input type="radio"/> In Home <input type="radio"/> Out of Home: Relative/Non-Relative <input type="radio"/> Foster Care	
II. FOR COALITION USE ONLY		
	<input type="checkbox"/> Income Eligible <100%	<input type="checkbox"/> Income Eligible 150% - 200%
	<input type="checkbox"/> Income Eligible 100% <=150%	<input type="checkbox"/> OTHER
	<input type="checkbox"/> TANF "Child Only"	<input type="checkbox"/> TANF (Relative Caregiver)
III. Primary Purpose of Care: <input type="checkbox"/> PROTECTION		
Secondary Purpose of Care:		
	<input type="checkbox"/> Emergency <input type="checkbox"/> Therapeutic Plan <input type="checkbox"/> TANF At Risk (RCG)	
	<input type="checkbox"/> Employment <input type="checkbox"/> Work Activity <input type="checkbox"/> Education Activity (TED)	

SECTION C: AUTHORIZATION

Child care services are authorized for this client for approved activity(ies). The minimum hours of care per child includes hours per week for reasonable transportation time. *Children authorized to receive care:*

						FOR COALITION USE ONLY		
Name	SSN	Birth Date	Race/ Gender	Minimum Hours of Care/week	FAHIS Investigation Intake #	Center/Home Placed	Date Enrolled	Assessed Fee

Gross Monthly Family Income: _____ (Attach Income Documentation, if available)

Care Authorization from _____ through _____ (Not to exceed a 6 month period)

Comments: _____

SECTION D: AUTHORIZING SIGNATURE(S): I hereby certify that the information provided above is correct.

Applicant Signature: _____ Date: _____

Authorizing Worker: _____ Date: _____

Supervisory Approval: _____ Tel.: _____ Date: _____

Coalition: _____ Date: _____

THIS FORM IS VOID AFTER 10 CALENDAR DAYS FROM AUTHORIZATION DATE